THE RHODE ISLAND MEDICAL JOURNAL

Owned and Published by the Rhode Island Medical Society. Issued Monthly

VOLUME XI NO. 3. | Whole No. 222 | PROVIDENCE, R. I., MARCH, 1928 | PER YEAR $2.00 SINGLE COPY 25 CENTS

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ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE AT PROVIDENCE, R. I., UNDER ACT OF MARCH 3, 1879

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Issued Monthly under the direction of the Publication Committee

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ORIGINAL ARTICLES

THE PRESIDENT'S ANNUAL ADDRESS.*

By Henry J. Hoye, M.D.
Providence, R. I.

In accord with the by-laws of this association, it devolves upon me as retiring president to address the members on some phase of its work. First, I desire to express my appreciation of the uniform courtesy extended to me by the members of the association, which has added so much to the enjoyment of my term of office. We have been fortunate in having, I believe, very good programmes, in which men of distinction from other cities have played no small part. The attendance at the meetings has been good, and I have noted with pleasure that more members have taken part in the discussion of the papers, always a true index of the worth of a medical meeting. Surely one of the outstanding features of the past year was the joint meeting of the New England Heart Association with our association, when a number of the leading clinicians of Boston joined with our internists in a discussion of diseases of the heart. May I venture the hope that we definitely plan more such joint meetings each year, varying from time to time in the different branches of Medicine and Surgery and specialties?

Our association has a more important function than merely to gather once monthly for the reading and discussion of papers. There is besides the duty it owes the community in keeping it in touch with the great problem of caring for the sick and devising means for the betterment of their condition. So it is that I have thought it would be well to consider the hospital facilities of our city, and to see if there is not a gap between the institutional care of those patients suffering from acute diseases and those the victims of incurable disease. If there be such a gap as suggested, the problem must be put up to the community. Again to this problem must there not be added the urgent need of a psychopathic hospital? In the Rhode Island Hospital, St. Joseph's Hospital, Homeopathic Hospital and Miriam Hospital, ample provision is made for patients with acute illnesses, medical and surgical; the City Hospital cares for the patients with the contagious diseases, while cases of Tuberculosis are treated at the State Sanatorium at Wallum Lake, and many of the chronic type at the City Hospital and the St. Joseph's Hospital Annex at Hillsgrove. As for obstetrical cases, there is the splendid service of the new Lying-In Hospital. As you well know many of the incurable cases of various diseases are cared for at the State Hospital at Howard. But what shall we say of the chronic cases, as of heart disease, diseases of the arteries of various degrees, of the kidneys, lungs, liver, gastro-intestinal tract, bones and the nervous system, which comprise at present, a not inconsiderable number of individuals, which in the future will add to their number?

It would be well here to define chronic diseases in the words of Dr. Ernst P. Boas, Medical Director of the Montefiore Hospital for Chronic Diseases, New York, as "those which so handicap the patient and are of such long duration that they incapacitate him and make necessary medical treatment for a period of several months or more. By and large they are diseases of the middle aged and elderly and because of the increasing lengthening of the span of life are assuming an ever growing importance. They are diseases of obscure origin, the nature of which is ill understood, and which tax to the utmost the diagnostic and therapeutic skill of the physician and the resources of the hospital."

We all know that most hospitals refuse admission to applicants suffering from chronic diseases, and if on occasion such an individual is admitted, he is discharged after a short stay in the hospital, irrespective of his condition and, it is to be feared, with little done therapeutically to better his condition. At a large hospital in New York City, of 1320 applicants refused admission in two years, 306 or 23% were rejected because they were vic-

*Read before the Providence Medical Association January 2nd, 1928.

tims of chronic organic disease. Municipal hospitals are compelled to admit these patients but they are, as a rule, shortly transferred to the almshouse.

In our general hospitals, the chief interest of the visiting and house staff is centered on the acute cases. Patients suffering from acute conditions, whether they be medical or surgical, naturally attract the attention of the visiting men. These patients, as a rule, stay but a short time in the hospital, their beds are soon filled on their leaving, while in the case of the chronic patients their stay is one of several months. It is certainly true that a chronic patient might occupy a bed for three months, which, in the same period, could have been devoted to the care of eight or nine patients suffering from acute medical or surgical conditions, but from the humanitarian point of view, why should we refuse service to the chronically ill and bestow it upon those who are acutely sick? Of course, general hospitals cannot always avoid admitting patients with chronic disease, as I have mentioned before, and again a patient may be admitted for a supposedly short stay and remain for a number of months. Indeed, if one made a survey of our own hospitals here in Providence, he would doubtless find many suffering from chronic disease among the patients, although this is probably in contravention of the general hospitals' policy. In a survey of the hospitals of Cincinnati, carried out by Dr. Bachmeyer, it was found that about 25% of the hospital population on the day of the census could be classed as chronic. In all probability this would hold true in most cities. The name incurable should not be given to these patients, for it is generally taken to mean that we are helpless to do anything for them; whereas "cura" in the Latin means to care for, and therefore in this sense these patients can be cured as well as any others.

About one-half the cases coming to the dispensaries belong to the class we are discussing, and as Dr. Boas well says, "the dispensaries do not have as a rule, the equipment, personnel, nor tradition to do justice to these complex diseases." They wander disconsolately from one clinic to another, generally receiving little benefit, and all too often find their last haven in the almshouse. If these patients could be in a hospital for chronic cases under careful supervision, many would be restored to active life in the community, and therefore, economically, the gain would be very considerable. At the Cornell Clinic in New York City, where a careful analysis was made of patients coming to the Clinic, it was found that 58% had been sick more than six months before arrival there.

Recent statistics show that there are only about fifty-seven institutions on record under the general and much embracing name of "Homes for Chronic Invalids"; in about one-half of the states of our country there is not even a single institution of that kind on record. Is it because there is no need for such institutions? Or is it because the condition of these patients does not interest the medical men of the community? We believe there is a crying need at the present time to establish more institutions for chronic invalids, equipped to give these patients careful and conscientious study and scientific treatment for the purpose of improving their condition. From the point of view of institutional care as Dr. Boas says, these patients may be grouped in three categories. Class A. Those requiring medical study for diagnosis and treatment. Class B. Those requiring nursing care only. Class C. Those requiring custodial care only.

The management of each of these groups is a problem in itself and each class places different demands on institutional resources. It is most important to remember that patients do not remain indefinitely in one class. Thus a patient may be admitted in class A and in the course of a month so improve as to become a purely custodial case. On the other hand, it is just as common for a patient in Class B to develop some complication or aggravation of his illness which places him in Class A. Every Class C patient who dies is a Class A case during his terminal illness.

The proper care of a Class A patient demands a complete organization with a resident staff, an attending staff on which all the specialties are represented, complete laboratory, X-ray and operating room equipment, skilled nursing, and dietetic management. Class B patients require much less specialized attention but should command an excellent nursing service, controlled by a conscientious medical staff. Class C patients are retained in an institution not because they require hospital care, but because poverty makes their home care impossible. The problem is economic, not medical.

The patients who are the subject of this discussion form as Dr. Boas says in his paper. "The Challenge of the Chronic Patient," the bulk of the physicians private practice. Because of the complexity and chronicity of their illnesses, they are among the most difficult whom he is called upon to treat. A well-equipped and well-organized hospital for chronic diseases gives a valuable opportunity for continued study to the physicians on its staff and enables them to transfer to the community represented by their practices the advancement in the knowledge of chronic diseases achieved by co-operative investigation in an institution. Every medical student should receive part of his training in a chronic hospital. Progress in all lines of human endeavor depends upon systematic and co-ordinated study. The community that neglects its members who are suffering from chronic diseases, pays for its carelessness by receiving less efficient medical service. It becomes the duty of every institution that cares for the chronic sick, not alone to harbor these unfortunates until the disease has run its course, but also to be equipped for the study of the causes of the chronic ailments of mankind with a view to prevention.

Another urgent and pressing need in our community is the establishment of a psychopathic hospital. It is not arguable whether we ought to have such a hospital. The need is so very obvious that the only discussion ought to concern itself with not whether we should have one, but why haven't we one. As regards the diagnosis and treatment of early mental diseases, we are in the same position we were twenty-five years ago in the early diagnosis and treatment of Tuberculosis. While we have the hospital facilities for the treatment of advanced and well-established mental diseases, we haven't even the most inadequate hospital facilities for those early and border line cases of mental disturbance, which are becoming increasingly more frequent in our modern society, and which, if properly cared for, need never reach a mental hospital at all. Moreover, there is no way in which relatives of people who are presumed to be suffering from mild mental disturbance, can receive hospital diagnosis and treatment. It is erroneously believed that a psychopathic hospital will duplicate existing mental hospitals. Nothing could be further from the truth. The purpose of a psychopathic hospital is to keep people out of mental hospitals, or if not successful in that, to send to the mental hospitals only those who absolutely require it. As matters stand now, there is no way of preventing serious mental disturbance, a thing which could be done very easily many times, if facilities were provided for meeting this particular problem. Altogether apart from the medical aspects of early mental disorders there is the very important economic problem to be considered, because, were a psychopathic hospital available, many wage earners and many mothers of families could be cured of their mental disorders, were they seen early enough, and, therefore, need never enter a chronic mental hospital. Moreover, there is in Providence absolutely no provision for the care of acute mental disturbances or border line cases of mental disorder, such as are being met in the practice of every physician daily. If the main purpose of modern medicine is so far as possible to prevent disease, then a psychopathic hospital is an urgent need in every community. The strains and stresses of our contemporary industrial life are falling with increasing frequency upon the brain and nervous system generally. And this requires that we be equipped to care for the inevitable results of such strains and stresses. A psychopathic hospital if it is to serve the purpose for which it is intended, must be situated in the city, where its facilities may be utilized by those who may require them. To make a psychopathic hospital a department of a more or less remote hospital for mental diseases, is to defeat its purpose, because if patients are to avail themselves of its services, such a hospital ought to be placed in some easily accessible situation. Unless someone has had in his own family some acute mental disorder present itself, he is scarcely able to recognize the urgent need of a psychopathic hospital to help in the solution of these distressing problems.

In this brief and altogether too sketchy account of our present and future medical needs, I have stressed only those which appear to me to be the most important and have passed over many things which are worthy of our thought and discussion.

In conclusion, I would fail not only in duty, but in gratitude, were I not to mention the always loyal and painstaking efforts of our secretary, Dr. Peter Pineo Chase, who has served us so faithfully for seven years. And now, may I end as I began, with the expression of my thanks for the

honor you conferred upon me, when, a year ago, you placed me in the line of succession of a long roll of distinguished predecessors.

RELATION OF PRACTISING PHYSICIAN TO THE PUBLIC HEALTH PROGRAM.*

By NORMAN M. MACLEOD, A.B., M.D.
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President of the Rhode Island Medical Society

What is the public health program? Some time ago Sedgwick stated that every worker in public health should have a proper working theory.

The first working theory was that of Miasm —that is, that disease was transmitted through the atmosphere and that certain places were undesirable breeding places of disease. Hippocrates, in his book on Airs, Waters and Places, makes some interesting deductions. He says, "A city that is exposed to hot winds will have waters that are plenteous and saltish; the heads of the inhabitants are of humid and pituitous constitution, and their bellies subject to frequent disorders, owing to the phlegm running down from the head. Infants are subject to attacks of convulsions and asthma. The men are subject to attacks of dysentery, diarrhea, chronic fevers in winter. Pleurisies, ardent fevers do not often occur, for such diseases are not apt to prevail where the bowels are loose."

Later in the middle ages an addition was made to this theory, namely that the individual constitution or diathesis determined the susceptibility to disease as well as the character of disease.

The theory of the contagion of disease was formulated first by Fracastorius in Italy in 1546, but his theory was so far out of accord with the belief of his times that it was given no credence by his contemporaries.

The first real step in preventive medicine was taken by Jenner in 1796, and it is gratifying to Rhode Islanders that a physician of Newport was the first to use this new method in America. Dr. Benjamin Waterhouse, in 1801, inoculated the first person in this country. Then later Pasteur, by his experiments, added more light and since that time the progress has been steady and continuous. Bacteriology is now a well established branch of the study of medicine and as Welch so pointedly says, "Bacteriology in the last half century, by revealing the micro-organisms responsible for disease and providing methods for their study and behavior, has transformed public health from a blundering empirical set of doctrines to a science and laid secure foundation for its further development along scientific lines."

This, then, must be the working theory of the public health officials of today that acute diseases are caused by micro-organisms and can therefore be recognized and that diseases can be prevented if proper steps can be taken.

What is the relation of the practicing physician to this program? There is no doubt that the failure or the success of this program depends to a great extent on the proper relation of the two elements. It is true, however, that many physicians have been apathetic in their support of public health measures and not a few have been definitely antagonistic. There must be some reason or reasons for this attitude. Some of the reasons are valid or have been valid.

Public health is a new science and with all new sciences there are many individuals connected with it who are not well trained. This lack of training when combined with an over enthusiasm and a willingness to use the tremendous police power given to such individuals has often lead to friction and has antagonized many conscientious physicians.

Furthermore, the entrance of politics in health work has caused much suspicion and justly so. The average man, both physician and layman has a suspicious fear of politics and there have been many occasions when this suspicion has been well grounded. It is only fair to say that in later years this domination has been growing less.

Inadequate compensation leads to positions taken by idealists with tendencies toward social medicine or incompetents who need the money. There is also the danger of the man in general practice taking on duties that lead to a conflict between the public protection and his personal relation to his own patient.

A very real reason to many phyisicans is the danger that the continued development of public health will lead to state medicine in the curative field as well as in the preventive. This fear has been accentuated by the attitude of many welfare

*Read before the Rhode Island Medical Society, December 1, 1927.

agencies that advocate state medicine as a panacea. There is a definite place for the state in the public health program. In our complex life of today with its multiplicity of contacts, no individual can live to himself alone. But the responsibility of the state must be properly used so that individual effort will be allowed to function. A recent editorial in the Journal of the American Medical Association is as follows: "Society, acting through representative government, has responsibilities in medical and health matters, but the line of demarcation between what is public and what is personal in matters of health must not be pushed back by government bureaus until government has invaded the privacy of the home and stands at the bedside of the individual." Many physicians, who have a profound respect for the public health program and who are eager to support it in every way, are still fearful that the social point of view will work in an insidious way to bring about the socialization of the medical profession. This fear undoubtedly prompted another editorial which says, "Times change and we with the times. The socialist demands an organized state medical practice; the sociologist apparently sees an almost inevitable trend toward such practice; the socialized physician sees great efficiency in such practice. But the psychologist, the humanist, the great practitioners of medicine see no hope for the real cure of ailing humanity in mechanistic methods which discount individual relationships."

Finally the practicing physician has been disturbed by the tendency of many public health officials to seek legislation to bring about results that should be secured by education. The great tendency of this age is regulation by law and it has been well stated by some authority that if no new laws could be passed for 10 years and the time devoted to education concerning the laws now existent, the world would make a great jump in progress. This education should be two-fold—the education of the physician himself in the remarkable advance in preventive medicine and his responsibilities connected with it as well as the education of the laity. The stories of the past that seem old to medical men are ever new to the growing generation and the wonderful change that has been wrought in our civilization by the conquest of smallpox, typhoid and malaria, by the use of anti-toxin and by the great strides in infant welfare should be told and retold each year.

So far has been discussed the difficulties, or seeming difficulties in bringing about the proper relations between the physicians and public health officials. It is perfectly true that physicians have not always been co-operative because of pressure brought by patients. Failure to report contagious disease often results because of the inconvenience to the family of the patient. Many physicians have not helped as much as they could because of their own lack of knowledge and because they could not or would not change their routine. We are all creatures of habit and the physician is peculiarly so.

The proper relation can be secured by mutual understanding—the appreciation of the difficulties that each have to face. The physician should realize that the health officer has a hard position, that the number of times that he is praised is to the number of times that he is cursed is one to infinity; that the majority of public health officials are loyal, faithful servants of the community who have an ideal ever before them. The health officials, on the other hand, must remember that many of their duties were formerly performed by the practicing physician and that most physicians are individualists. If co-operation can be secured by mutual understanding then the future of the public health program is assured, for no real lasting success in promoting health of people and preventing disease can be attained without the active sympathy, support and participation of the profession. In closing may I commend to my fellow practitioners a statement on individualism presented by one Lloyd Paul Stryker.

"Individualism is vital to the welfare of the physician, it should be fostered and encouraged, but individualism which refuses to unite and to co-operate to bring about the greatest good for the greatest number may become a danger and a menace to the accomplishment of the great aims for which physicians have dedicated their lives, strength and high courage."

A STUDY OF EIGHTY CASES OF ACUTELY PERFORATED GASTRIC AND DUODENAL ULCER.*

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This paper is based on a critical study of eighty cases of acutely perforated peptic ulcer. They have been studied for a determination of the following points: (a) symptoms of onset; (b) presence or absence of previous gastric symptoms; (c) the condition most frequently beclouding the real diagnosis; (d) the effect of time interval between onset of perforation and operation upon the mortality; (e) the type of treatment; (f) the use or non use of drains; (g) the percentage of men and women affected; (h) causes of death; (i) the mortality rate; (j) the end results.

(A and B) All but four patients gave a history of some previous gastric trouble which could be ascribed to an ulcer existing some considerable time ante-dating the perforation; this gastric history varied from the shortest period of one week to the longest period of twenty years. It is obviously difficult to assume that all these gastric symptoms were related to a pre-existing ulcer, but in all of them, the past history contained factors which we could, in all justification, accept as being reflective of an existing or formative ulcer, especially in view of subsequent developments. The intermittent attacks of gastric disturbances are well brought out by the patients and in themselves seem to point to a tendency for an ulcer to undergo periods of remission from its acute pathology without treatment. The story of the perforation as seen from these cases has such a characteristic and constant sequence, that one could almost write the symptoms beforehand, read them to the patient, and find that they described quite accurately the specific case under consideration.

Suddeness of onset is characteristic and has not failed to be present and particularly mentioned by any patient in this series. This sudden onset of terrific pain has often been preceded by prodromal symptoms of slight indigestion, rumblings in the stomach, or mild nausea; in others, a sudden sharp intense pain, often while the patient was at work, was the first indication of trouble.

The pain of perforated ulcer awakening a patient from a sound sleep, has in this series, with but four exceptions, been due to a duodenal ulcer. The regularity of this time element of pain being associated with duodenal and not gastric ulcer, is very vividly brought out in these cases; sixteen out of twenty patients with perforated duodenal ulcer having been awakened from their sleep with pain. The pain of perforated peptic ulcer was graded from a general unlocalized abdominal discomfort to a definite sharply circumscribed area, usually in the epigastric region, to the right or left of the median line. Several patients have spoken very bitterly of the uncomfortable pain at the tip of the right shoulder, and some, of its extending into the back. The pain occuring over the appendix region and often complicating the real diagnosis, is not a referred pain, but due to irritation of the peritoneum from the downward drainage of the gastric or duodenal contents following the perforation. This matter will be more completely dealt with later. Abdominal rigidity and spasm are very early accompaniments of the pain complaint, and in few cases, except an acute pancreatitis, will one, so early in a surgical belly, find so boardlike a general rigidity as in a perforated ulcer. The severity of the symptoms are determined by the size of the perforation, the amount of leakage from the stomach or duodenum, and by the rapidity with which nature seals over the opening in the viscus. When one does gastro-intestinal surgery and recalls the ease with which the mucous membrane will bleed, it becomes a matter of speculation as to why, in perforated ulcers. Bloody vomitus is so infrequent. While vomiting has been a frequent complaint, in only seven cases was there fresh blood or coffee ground particles suggestive of digested hemoglobin.

We have been impressed with the discrepancy between findings at operation and the physical condition of the patient on admission as affected pulse and temperature. Time after time, a boardlike rigidity, a history of repeated vomiting and terrific pain, would be productive of a pulse of 80 or 90 and a normal or only slightly elevated temperature. This does not mean that this series does not show patients reacting most severely to the

*From the 1st. Surgical University Clinic of Prof. A. Jirásek. Read before the Jacobi Medical Club of R. I., Sept. 28th, 1927.

acute peritonitis following upon the perforation, with a pulse of 110-140, with high temperature and other signs of intense shock. But that such an abdominal condition can occur and show such comparatively mild pulse and temperature reaction is worthy of remembrance. As exemplifying this statement we mention a patient with a perforation of 60 hours duration with a pulse of only 112. In this respect it is analogous to some cases of perforated appendix with a pulse only slightly increased and an almost normal temperature.

(c) As to diagnosis: the records show that the condition most frequently leading one astray, was to mistake a perforated ulcer for an acute appendix. Mistaken diagnoses occurred in 22 cases in this series as shown in the following table:

TABLE 1.

Conditions confused with acutely perforated ulcer:

Acute Gall Bladder	3 cases
Acute Appendicitis	16 cases
Acute Pancreatitis	1 case
Traumatic Rupture of Stomach	1 case
No Diagnosis	1 case

To call a perforated ulcer an acute appendix, is, in spite of the different regions involved, not as impossible as would appear on first thought. The perforation of the ulcer is followed by leakage into the free peritoneal cavity of gastric or duodenal contents, and its pathway is along the ascending colon down the caecum and then into the pelvis. The irritation produced by the chyme, free HCl or bile or all of these combined, around the appendix, is so great, that this new pain, by its intensity often masks the symptoms of the original pathology. One may argue from this that the most advantageous place for drainage in perforated ulcers would be the appendix region—to drain from the pelvis only inviting a further area to be involved by the gastric and duodenal outpouring in its downward course. A careful history, provided the patient is in condition to give one, is of utmost import to avoid making a wrong diagnosis. (d) It must present itself as a self-evident fact that the time element as between onset of the perforation and the operative treatment, plays an important part in the prognosis. We have here a condition doing constant harm to the body cells by its outpouring into the free peritoneal cavity of material both toxic and irritating to the system. The sooner one can eliminate this vicious condition, the sooner does the individual begin his fight to combat the harm already done. We have found in this series that the time elapsing between perforation and operation varied from 3-96 hours and that it had a decidedly determining effect upon the eventual result. The appended table is self-explanatory:

TABLE 2.

Number of cases operated on up to 6 hours after perforation and result:

Total	12 cases
Recovered	10 cases
Died	2 cases
Mortality	16 2-3%

Number of cases operated on from 6 up to 12 hours after perforation and result:

Total	21 cases
Recovered	15 cases
Died	6 cases
Mortality	28½%

Number of cases operated on from 12 up to 24 hours after perforation and result:

Total	27 cases
Recovered	18 cases
Died	9 cases
Mortality	33.3%

Number of cases operated on 24 hours after onset and result:

Total	20 cases
Recovered	3 cases
Died	17 cases
Mortality	85%

These statistics very strongly bear out the fact that the sooner operation follows perforation the better is the prognosis. (e) This Clinic treats its perforated ulcers on the principle of entering the abdomen quickly, and getting out of it as quickly as consistent with the proper performance of the surgery indicated. In other words, do as much as the patient's condition absolutely demands and no more. It countenances with considerable impatience the advocacy of *routine* gastro-enterostomies or resections in acutely perforated ulcers. The treatment given here is to cauterize the ulcer with the actual cautery, close the perforation with a layer of penetrating

sutures, and cover this with a row of Lembert sutures; to cut off a piece of omentum and sew it over the final layer of sutures as an added protection against leakage. The rapidity with which this free omentum graft causes adhesions between itself and the ulcer area is most surprising; it has been found, in those cases coming to autopsy shortly after operation, that 12 hours is time enough to produce adhesions of sufficient firmness to occlude the perforated area. In only four cases was a posterior gastro-enterestomy done and this because of pyloric occlusion following suturing of the ulcer; in one case, a resection, because the size of the perforation and the great degree of induration about it, making sewing impossible; and in one instance, a rubber tube was placed into the perforation converting it into a gastrostomy, also because of the impossibility of suturing. In this series no ulcer was excised with the knife, the actual cautery being used, and no Finney operation was performed. In contrast to this comparatively simple treatment of a serious condition, it is of interest to make slight comment on the principle advocated by Prof. Kreuter.[1] He strongly recommends resection in all cases of perforated ulcer, except in the most extreme moribund condition of the patient. It seems like flying in the face of established surgical principle to undertake so formidable a procedure with the condition of the patient so precarious, and septic material likely to be disseminated over parts of the peritoneal cavity which may as yet have escaped infection.

(f) There is a minority of surgeons who possesses the masterly courage to close the abdomen following an operation for perforated ulcer without the use of drains. In this series of cases only four were treated without drainage—the remainder with drainage; the drainage material being gauze or cigarette drain, and the location either at the site of perforation, at the appendix, in the pelvis, or the combination of any of these regions. The average length of time for which they were left was 6 days. In this clinic pelvic drainage is most commonly employed unless a right rectus incision was made because the condition was erroneously diagnosed as an acute appendicitis, in which case drainage both in the ileo-caecal and pelvic regions were used. (g) This series of cases had ten female patients, 12½%, as compared to 87½% of male patients; their ages varied from 22 to 56 years of age.[2] Autopsies were done on all patients who died and the causes of death pathologically determined; they were as follows:

TABLE 3.

Loosening of suture with subsequent peritonitis	1 case
Acute dilatation of heart	2 cases
Lobar or broncho-pneumonia	5 cases
Hemorrhage	1 case
Peritonitis	All other deaths

As was to be expected, peritonitis was a major cause of death and complications such as cardiac failure and pneumonias contribute to the causes of mortality. We have had no deaths from subphrenic abscess. It is of interest to note that in only one case could death be attributed to a faulty suture technique—this undoubtedly contributing to the maintenance of the terminal peritonitis. The location of the ulcers treated in this series is given in the following table:

TABLE 4.

Small curvature	30 cases
Anterior stomach wall	20 cases
Duodenum (ant. wall)	18 cases
Pylorus	6 cases
Large curvature	3 cases
Duodenum (post wall)	2 cases
Post wall of stomach	1 case

As the value of every effort must be interpreted in the light of its final accomplishment for good, we gave in some considerable detail, the operative mortality (see table 2). Several factors must be borne in mind forming any conclusions based on these figures. They must be studied in conjunction with the time interval between onset of the rupture and operation, for it would be manifestly unfair to expect the same results to follow an operation done 15 hours following a perforation as would one done five hours after. It must also be taken into consideration that the majority of these patients were of the hardy peasant type, living

[1]Kreuter E. Prof. "Ueber die Zulassigkeit der Primaren Magenresektion bei frei Perforierten Magenduodenalgeschwuren." Klinische Wochenschrift No. 16, Pages 742-743. April 16, 1927.

[2]One of us (M. A. P.) has had occasion to operate for a perforated gastric ulcer on a youngster of five years; the correct diagnosis not being made until after the abdomen was opened.

some considerable distance from the Clinic and not accustomed to seek help for sudden aches and pains, sometimes going about their accustomed duties for hours following an acute perforation. The death rate in this series was 42½%. The mortality in the 31 cases of Prof. Kreuter operated on during the past five years by palliative measures was 38.7%; following radical treatment in 31 cases his mortality was 16.2%. His table follows (1):

	6 hours deaths	12 hours deaths	Over 12 hours deaths	Mortality deaths
Palliative	8.1	9.1	14.11	31.12—38.7%
Radical	17.1	7.1	7.3	31.5 —16.2%

This matter of mortality rate is well expressed by Dr. J. B. Stenbuck[3] — "of the 88 patients 23 died i.e. 31%. The death rate in the practice of surgeons in different hospitals and different localities may vary considerably, for there is not nearly the uniformity in percentage of mortality as in the case . . . . of acute appendicitis. From year to year the mortality changes, so that in one the rate is 0 and in another as high as 54%." A follow up record of 26 patients of this series gave the following results:

Absolutely well	18
Occasional mild gastric symptoms	3
Relieved 6 to 9 months after operation	4
Failed in any improvement	1

Conclusions and Summary.

(1) The symptoms of perforated ulcer present themselves with such a degree of regularity that the diagnosis should not often be missed. It is a disease of early maturity to past middle age. (22 to 56 years in this study.)

(2) The conditions most likely to be confused with it are acute appendicitis; more remotely an acute pancreatitis, or gall bladder.

(3) 12½% of patients in this series were women.

(4) The palliative treatment for perforated ulcer was done on all but five cases and in these further surgery was necessary because of very definite indications.

(5) The mortality was 45½%. The maximum of recoveries occur in those cases operated on up to the first six hours; it is still favorable up to 12 hours, from which time on there is a rapid fall in the number of recoveries.

(6) The shortest time interval between perforation and operation with recovery, was 4 hours—the longest was 72 hours.

(7) All but four cases gave a past history of gastric symptoms.

(8) The pulse rate is no criterion as to the findings at operation, nor does it bear any constant relation to the time interval as between perforation and operation; we have in this series variations from a pulse of 120 four hours after perforation to one of only 80, eighteen hours after perforation. The pulse rate is influenced by many factors especially the size of the perforation, its proximity to a meal and the speed with which Nature seals the opening against leakage.

(9) We feel that drainage still occupies an important place in this type of surgery and should be placed either to ulcer, right iliac region or to the pelvis.

(10) A diffuse peritonitis is the immediate cause of most deaths.

(11) The overwhelming frequency of perforation, either of the stomach or duodenum, occurring near the pylorus, leads one to feel that this area, through its constant traumatization during the process of digestion, is a "locus minoris resistante."

(12) It is a significant fact that 16 of our 20 perforated duodenal ulcer cases were awakened from a sound sleep.

(13) The order of frequency of the location of the ulcers in this series were: small curvature, anterior stomach wall, anterior duodenal wall, pylorus, large curvature, posterior duodenal wall, and posterior wall of stomach.

(14) We cannot conceive of radical surgery as a routine measure in the treatment of perforated ulcers. We realize its place and have used it in certain well-defined cases; but to assign to it the same frequency of procedure that is accorded it in chronic ulcers is, in our opinion, unjustified. A masterly restraint of ambitious surgery will tend to a higher degree of recoveries from a condition already fraught with considerable danger.

[3]Stenbuck J. B. "Causes of Death following operations for Perforated Gastric and Duodenal Ulcer." Annals of Surgery Vol. LXXXV., Page 713. May, 1927.

THE RHODE ISLAND MEDICAL JOURNAL

Owned and Published by the Rhode Island Medical Society
Issued Monthly under the direction of the Publication Committee, 106 Francis Street

Advertising matter must be received by the 10th of the month preceding date of issue.

Advertising rates furnished upon application to the business manager, CREIGHTON W. SKELTON, M.D., 166 Broad St., Providence, R. I.

Reprints will be furnished at the following prices, providing a request for same is made at time proof is returned: 100, 4 pages without covers, $6.00; each additional 100, $1.00; 100, 8 pages, without covers, $7.50; each additional 100, $2.80; 100, with covers, $12.00; each additional 100, $4.80; 100, 16 pages, without covers, $10.50; each additional 100, $3.00; 100, with covers, $16.00, each additional 100, $5.50.

SUBSCRIPTION PRICE, $2.00 PER ANNUM. SINGLE COPIES, 25 CENTS.

Entered at Providence, R. I. Post Office as Second-class Matter.

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EDITORIALS

INCREASING HOSPITALIZATION

It is astonishing to learn that more than 60% of all deaths in New York City take place in hospitals. It only confirms the fact of greatly increased patronage of hospitals by the sick and injured.

Until recently hospitals were constructed for the care of the sick among poor people. It is only recently that people of means have overcome their aversion to hospitals. It was the excellent medical care and comforts supplied in private wards of charity hospitals which brought this about. The private patients accepted in charity hospitals were first taken in to accommodate the visiting staff and add something to the revenue of the hospital. Those who were able to pay began to learn that the charity patients were receiving treatment that could not be furnished at home at any cost. This is particularly true of patients requiring surgical attention. Not so many years ago considerable home operating was done but there is now very little of it except where hospitals are not accessible. The result has been that during the last

ten years or more, a very large number of hospitals have increased their capacity for private patients and many private hospitals have sprung up all over the country.

Strange as it may seem the number of charity patients during the war and for a period thereafter, shrunk. This was indicated by the number of empty beds in the hospitals, particularly in medical wards. At the same time the number of people applying for treatment in the out patient department noticeably decreased. This, of course, was a result of the great prosperity enjoyed by the country. During the last five years the amount of charity work has increased. However, the growth of hospitals recently has been largely due to making provision for private patients rather than for charity patients.

It is interesting to speculate upon what effect increased hospitalization will have on the practice of medicine and the kind of service which the public will receive. In the large cities where housing and the servant problem is a distressing one, hospitalization of people who can afford to pay the hospital and for medical services will probably increase. It will, however, be governed by the prosperity of the country and the percentage of people who are able to pay for such services. Hospitalization of this class of patients is welcomed by physicians, particularly in communities where there are both closed hospitals and hospitals to which all reputable physicians can send their patients.

The hospitalization of charity patients, however, presents a rather different problem. The *per capita* cost of caring for these patients has doubled during the past ten or fifteen years. This has brought about the necessity of providing better laboratory and X-ray service, the introduction of social service, more expensive forms of treatment and the demand from the public that better food, service and nursing care be provided. In order to meet the demands made upon them hospital superintendents endeavor to shorten the stay of each patient as much as possible. Convalescence can as well take place at home or in a convalescent home with which many hospitals are now supplied.

This shortening of hospital stay is a very healthy sign and a very significant sign. It reflects creditably upon the promptness of treatment and upon its efficiency. Even though the per capita cost is high the patient gets something for his money and the total cost to the hospital for each patient may be no greater than when the stay was twice as long. The modern hospital should not be a boarding house. The expense is too great.

For diseases of mild character and obvious diagnosis, and for convalescents, home treatment is cheaper even if the community has to supply physicians to the homes of the very poor. This is a phase of medical service which should be given more attention and study. Ambulatory patients can, of course, go to a doctor's office or attend a clinic.

Many physicians complain that the hospitals are taking bread out of their mouths. This may be true but the medical profession must realize that people will go where they can receive the best service. If physicians will only keep up to date, ally themselves with hospitals, if possible, and utilize the hospitals to assist them in diagnosis and treatment they would have less reason to complain.

The practice of medicine is in a transition stage. No one really knows what should be done but a study of the problem from a broad viewpoint and the application of common sense will lead to a solution beneficial to the physician as well as the public.

THE DIAGNOSTICIAN

The division of medicine into various specialties has resulted from the increasing mass of medical science which has become too great to be mastered by any one mind. The division is also economically important. The surgeon, who must keep operative appointments, cannot be hampered by obstetrical practice. The obstetrician must not take the chance of infection from contact with infectious diseases. The busy practitioner of medicine has not time to perfect himself in surgical technic. And so around the circle. Of all medical specialists the diagnostician should hold the most important position. Without accurate diagnosis, all medical work is useless and often harmful. The diagnosticians of the past generation were trained in the autopsy room and retained a connection with the pathological department which served as a constant check on their accuracy. Some of these men were credited with extensive series

of diagnoses free from error for periods of years. A mistaken diagnosis was a source of deep chagrin. The present tendency is to neglect the autopsy room and the pathological laboratory as checks on accurate diagnosis, depending on blood chemistry rather than trained intuition for diagnosis. The results, whether from inaccuracy in the tests or from misinterpretation of data, are often faulty. A correct diagnosis is not a matter of course but a cause for congratulation. There is a distinct field for the diagnostician, a specialist trained in the autopsy room and the laboratory, and familiar with every aid to diagnosis. With some natural gift of intuition, with proper training, and with the benefit of all the modern physical and chemical aids to diagnosis, this specialist should soon dominate all others.

INVENIMUS EAM IN CAMPIS SYLVAE

It is with considerable satisfaction that the success of the out of door propaganda which it has been urging for so long. Indeed, sports now occupy such a conspicuous place in the life of all sorts and conditions of men that there is a serious question if they may not be overdone. In the incessant and untiring preaching of the great out of doors, in the broadcasting of popular articles in magazines by medical writers, and in private consultation there has been no dispute whatever as to the beneficial and healthful effects of out of door life and exercise—the profession has been and is unanimous and agreed. The occasional absurdities of the lay press can be forgiven because of the tremendous impetus it has given the movement by its wide spread publications. The occasional death from over-exercise in those who should not have taken it is no argument except that one should know oneself and not draw from an already exhausted physical account. It is rather an argument for more intelligent exercise, for the supervision of such exercise, and for more frequent examination of the individual. These occasional examinations have been interpreted as causing introspection and the exaggeration of the importance of existing physical defects. They are rather the means of prolonging life, of partial if not complete restoration to health and the replacement of a comfort and happiness which comes only with physical well being and satisfaction.

Popular articles upon diet are for the most part founded on scientific principles, most of them are by physicians; if the weight be reduced for esthetic and personal reasons, they participate in the many physical benefits such a process confers; the degenerative processes due to overnutrition are postponed or eliminated. It might seem that in many ways people are becoming sensible and perhaps economical. The foibles of fashion and so-called society are not always beneficial to the race but for this one the physical economist should be thankful. The same cannot be said for prevailing styles of clothing, for many persons are not suitably clad in the colder months. The doctrine of the same clothing the year round is neither sensible, hygienic nor scientific and the profession should urge, even to its profitable patients, enough clothing to keep the body warm and the wintry blast from the great vessel area and other vulnerable and susceptible parts. Many persons are in a continued state of ill health because of overheated rooms, which must be kept so in order to keep the deluded warm; pneumonia, colds and their many sequelae result from this absurdity of fashion.

Of the beauty parlor, of its many ramifications and arborescent invasions of the private purse, we must confess to mingled feelings. Of comic strip amusement at the results of its vogue and of sorrow that so many spend so much upon that which satisfieth not—also that the beauty therapeutist is paid and the doctor is not. Another argument for hygiene and out of door life; for extended observations in lands where the remarkable are those who do use cosmetics have conclusively shown that simplest of ablutions produce matchless complexions and that complexity of preparations are not necessary or desirable. Some of the questions asked prospective licensees are of interest and the medical man is furnished food for thought and self-examination—in fact, one doctor was overheard asking another, "How many bones are there in the cranium?" He replied, "What's the cranium, anyway?"

As to the components which combine to make the fingernails, we rather think that we should be obliged to consult our library rather than the tables of our memory which is befogged by recollections of chitin, unguiculus, phosphatic collagen, and other phantasmagoria. As to the technical

word for itch, the question might arise, what kind and where? Not long ago one of the questions asked of nurses was, "Describe the ankle joint." This would be rather a large order even for a surgeon. We should like to see an ankle joint constructed according to the descriptions offered at this examination for nurses. The wholesale rejection of experienced hairdressers is an interesting subjection for inquiry, thought and perhaps remedy.

DE SENECTUTE.*

WILLIAM R. WHITE, M.D.
Providence, R. I.

You all have read or else been told
How once, at time now grown quite old,
A learned Roman speeches made
That bright in classic lore have stayed.

Likewise you this must also know,
That Roman's name was Cicero;
And that the speeches of the sage
Embodied thoughts about old age.

In Latin tongue, so rich and pure,
That it through centuries must endure,
His mind with soundest wisdom filled
Behind the voice that thousands thrilled.

And thus it was that Cicero,
So many hundred years ago,
Enrolled himself on scroll of fame
Where classic glory blazed his name.

And now my friends we'll take a drop,
Indeed 'twill seem much like a flop;
From ancient days and classic Rome
Let's come right here and feel at home.

Of course both you and I well know
I can't orate like Cicero.
But still I'll try on this our stage
To talk to you about old age.

Tonight of course I know its true
I older am than most of you.
But what tonight is true of me
As true, sometime of you may be.

Therefore I beg you listen well
To this queer tale I have to tell.
I'll hasten on, and what is worse
I aim to tell you it in verse.

I've seen the years go fleeting by
And dates and figures do not lie;
Sometimes I seem almost to doubt
My span of life's so nearly out.

I stand before you quite erect,
Senile decay do you detect?
Is voice with which to you I speak
What you'd call halting, thin or weak?

Indeed, I want it understood
My health right now is very good.
In fact I can quite truly tell,
Than now I never felt more well.

My strength it does not overtax
To push a saw or swing an axe;
In winter I don't need to go
For outside help to shovel snow.

And when the street I walk along
I feel I'm going fairly strong,
And it would "faze" me not at all
To knock some flies or chase a ball.

But wait, it would indeed be strange
If all these years had brought no change.
Some changes are for you to see,
While others will be told by me.

Some things 'twere well for you to learn,
For quite too soon 'twill be your turn.
I ask you to remember this
The wheel of time ne'er makes a miss.

So when the try-out comes to me
I know full well how it will be.
To fight life's fight and play life's game
I conscious am I'm not the same.

For active work I rank myself
As full three quarters on the shelf;
But let me trail along our road
And do my bit with lighter load.

While on the whole I think that I
As old men go am fairly spry,
Yet gladly I depend on you
To do the things I cannot do.

---

*Read before the Providence Medical Association, December 5, 1927.

Beginning now right at my crown
I'll comment make as I pass down.
With your own eyes you now will see
What heaped up years have done to me.

I had a lot of dark brown hair,
It's mostly gone, I wonder where.
Artistically on side 'twould part,
Now broad midway allows no art.

To tell you when or how it went
I think I'd best make no attempt.
In loving kindness let me say
Some younger docs are that same way.

A beard I had, dark brown and black,
The color's gone, it won't come back.
Instead you see, to take its place,
A pallid fringe surrounds my face.

I once had vision, strong and clear,
It normal was for far and near.
But now a lens I surely need
Or else I cannot write or read.

Though I see name on trolley car
A block away or twice as far,
Yet this thought often startles me,
Without my glass I'd helpless be.

My hearing once was also clear
But now in front I sit quite near;
Or else I have to count my cost
When some of speaker's words are lost.

I once had normal set of teeth,
Sixteen above, the same beneath.
But now I find within my face
By far too much of toothless space.

Although I've lingered pretty late
As yet I've worn no dental plate.
I would not say that "beats the Dutch,"
But some, less old, can't say as much.

In front a few incisors meet,
So, like a rodent, I must eat.
It's known to me, likewise to you,
A guy needs teeth to rightly chew.

And as I also fully know
I can't expect new teeth to grow,
I think quite soon 'twill be my pleasure
To have some dentist take my measure.

As to my weight, I tip the beam
At notch the same as when eighteen.
All I will say concerning that,
I've been too spry to gather fat.

Too many friends who took on weight
Too early reached the pearly gate.
So to myself I really seem
More safe for being rather lean.

Objectively need you be told
That I've been busy growing old?
Subjective proofs that you don't see
Most vividly are known to me.

When young I rarely knew fatigue,
I'd walk a mile, ten miles, a league.
But now at first or second mile
I slow me down and rest a while.

I'd hay twelve hours in summer's sun
And play baseball when work was done.
But now when tired, with weary head,
I play not ball but seek my bed.

It shames me not that I confess
Endurance, yes, and strength are less,
But glad am I and thankful too
There's still a lot that I can do.

I've less ambition, much less zest,
I seek more leisure, need more rest.
I hustle less; in life's great race
I watch my step and know my place.

Of mental strength I'd best not speak,
You're hearing proof it's pretty weak.
But if not old, what fun I'd miss,
The writing up of theme like this.

One may surmise I've in reserve
A good supply of active nerve,
Or food like this I would not serve;
For same your thanks I don't deserve.

My memory's keen for long ago;
For yesterday it's mighty slow.
I put my glasses, pencil, pen
In some convenient place, and then,

I look for them and almost swear
Because they are no longer there.
I tell my wife where they should be
And knowingly she looks at me,

And soon returns, with smiling face,
The lost she's found in different place.
I growl and say "Who moved my things?"
She says, "Perhaps they grew some wings."

Sometimes when on the street I see
A man in haste approaching me.
"Why Doctor White! how do you do?"
I grin and say, "The same to you."

But all the time I pound my brain
And wonder, what can be his name?
His eyes and nose and mouth and chin
Remind me that I once knew him.

I question him to find a clew
That might reveal the name I knew.
The name my memory cannot trace,
The name I can't make fit his face.

Embarrassing, I'll say it is,
To greet a once familiar phiz;
To look, and think a great big bluff,
To lose the name is surely tough.

While toys with which I used to play
I see as though 'twere yesterday.
My playmates' names come back to me
As I their faces seem to see.

Indeed I think it true must be
That memory is a mystery
How things all through ones life will stay,
While one forgets since yesterday.

This second childhood why deplore?
I'm seventeen and three score more
And while my strenuous work is done
I still do something, have some fun.

When here tonight to you I came
I needed neither crutch nor cane.
When I ascended yonder stairs
I think I took the steps in pairs.

I do not need excuse to give
That I can now more restful live.
I do not care o'er world to roam,
My greatest joy I find at home.

I have three elements of wealth,
My home and happiness and health.
Companionship and kindest care,
My lightened burdens others share.

Three things that help my heart's desire,
My book, my dog, my open fire.
When tired I close my eyes and dream,
My life seems pictured on a screen.

Thus I review from time to time
Experiences that once were mine.
Life's joys and hopes and sorrows too
Again appear within my view.

What marvelous gift it is to age
To thus again review life's page.
Through three score years and ten to roam
Till back again at boyhood's home.

Yes memory is a wondrous gift,
Enabling us in thought to drift
Again amidst life's sweetest joys
That have been ours as men and boys.

How long may one desire to live?
As long as service one can give,
And help promote a kindly plan
For uplift of ones fellow man.

The years once lived are past and gone,
One's life progresses on and on.
This gravest question man must face,
The future of the human race.

The aging man must answer crave,
What fate awaits beyond the grave?
When man lays earthly burdens down
Will conscious life existence crown?

Will he again behold once more
His loved ones who have gone before?
Will recognition bless him then?
Will they know him? Will he know them?

That knowledge is denied us here,
What waits beyond is not made clear.
When final summons comes to me
Shall I then know, shall I then see?

My fellows you have listened well
To queersome tale I had to tell.
I promise that my rythmic pen
Shall not get busy soon again.

I know I'm way behind the times
Though I can still coaptate rhymes,
So on the whole it seems to me
That this had best my swan song be.

LETTER TO THE EDITOR

My dear Editor:

It was gratifying to the State Board of Health to know that the Rhode Island State Medical Society endorses fully the plan for a survey to be made in this state of the causes of maternal mortality. This interest was manifest by recent action of the State Medical Society.

This survey will be made by a representative of the Children's Bureau in Washington. It will not be made in such a way as to embarrass the physician in his practice. Information will not be sought in the homes, but through the co-operation of the medical men.

When we consider that maternal mortality is one of the dark spots in public health work in the United States, this country with all its wealth standing next to the lowest in the list of twenty countries, makes the problem appear to me one that should arouse the interest and concern of all medical men. I was gratified to learn that Rhode Island makes a better showing in regard to this matter than any, except possibly one state.

I shall be very much pleased if every physician in this state when called upon by the investigator will supply such information as he may have, thereby lending great assistance in this important matter.

Respectfully
B. U. RICHARDS, M.D.,
Commissioner of Public Health

SOCIETIES

PROVIDENCE MEDICAL ASSOCIATION.

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Henry J. Hoye, Monday evening, December 5, 1927, at 8:47 o'clock.

The records of the last meeting were read and approved. The secretary announced the nomination of officers and committees for the ensuing year.

NOMINATION OF OFFICERS

For President—Edward S. Brackett, M.D.
For Vice-President—Arthur H. Ruggles, M.D.
For Secretary—Peter Pineo Chase, M.D.
For Treasurer—Charles F. Deacon, M.D.

For Member of the Standing Committee for five years—Henry J. Hoye, M.D.

For Trustee of the Rhode Island Medical Library for one year—N. Darrell Harvey, M.D.

For Reading Room Committee—George S. Mathews, M.D.; Elihu Wing, M.D.; Guy W. Wells, M.D.

For Delegates to the House of Delegates of the Rhode Island Medical Society:

E. S. Cameron, M.D.	C. W. Skelton, M.D.
W. H. Higgins, M.D.	R. S. Wilcox, M.D.
A. J. McLoughlin, M.D.	J. W. Sweeney, M.D.
P. P. Chase, M.D.	P. Appleton, M.D.
F. E. McEvoy, M.D.	W. Pickles, M.D.
A. Corvese, M.D.	A. A. Barrows, M.D.
M. Adelman, M.D.	G. H. Crooker, M.D.
P. C. Cook, M.D.	C. H. Jameson, M.D.

W. S. Streker, M.D.

The first paper of the evening was read by Dr. John W. Keefe on "Aids to Greater Safety in Operation." He first reported an obstetrical case. A careful estimate of the patient's ability to stand operation comes first. The surgeon himself should acquaint himself with all details before operation. Not one portion of the anatomy or phase of the patient should obscure the whole, and the specialist should be first of all a general practitioner. He discussed some of the general problems of the surgeon, dwelling particularly on the loss of sponges in the abdominal cavity, and again stressed the surgeon's broad view of his cases. The paper was discussed by Dr. A. T. Jones, Dr. Charles W. Higgins, Dr. I. H. Noyes and Dr. Keefe.

The second paper was by Dr. Frank J. McCabe on "Focal Infection and Its Relation to Ophthalmology." The primary foci are usually along mucus surfaces on the skin. Secondary can occur in lymph nodes or deep tissues. The most important location is about the mouth and nose. He gave a statistical report on 200 eye cases showing the distribution of foci throughout the body. The paper was discussed by Dr. L. B. Porter, Dr. G. W. Van Benschoten, Dr. C. A. McDonald, Dr. Mihran Chapian, Dr. R. F. Hacknig, Dr. H. C. Messinger, and Dr. McCabe.

The third paper, by Dr. William R. White, was entitled "De Senectute." This was a delightfully rhymed statement of Dr. White's estimate of his present situation and views of life, and was

greeted with a great burst of applause from the meeting. On the motion of Dr. A. T. Jones, Dr. White was given a rising vote of thanks.

The meeting adjourned at 10:38 P. M., Attendance 72. Collation was served.

Respectfully submitted,

PETER PINEO CHASE, *Secretary*

The annual meeting of the Providence Medical Association was called to order by the President, Dr. Henry J. Hoye, Monday evening, January 2, 1928, at 9 o'clock. The records of last meeting were read and approved.

The reports of the Secretary, Treasurer, Standing Committee and Reading Room Committee were approved and ordered placed on file.

The President's annual address was read by Dr. Henry J. Hoye. He discussed the hospital situation in Providence with reference to the care of chronic diseases. These are usually of the middle aged and elderly class which is being increased by modern sanitary and hygienic methods. Only occasionally do these get into hospitals primarily for acute cases. With proper care which they do not get in the usual clinic many can be returned to active life. Class A. Those requiring medical study for diagnosis and treatment. B. Those requiring nursing care only. C. Those requiring custodial care only. Patients may change from class to class. These cases comprise a large proportion of private practice and such hospitals offer opportunity for working out many problems. Every medical student should receive part of his training in such a hospital. A psychopathic hospital is needed here. The only question is—Why do we not have it? Such a hospital would save many cases now coming to mental hospitals. Economically this would be valuable returning many to active life. It should be in an easily accessible place.

It was voted to suspend the by-laws and have the Secretary cast a ballot electing Dr. Edward S. Brackett president for the ensuing year. He was escorted to the chair by Dr. Kingman and Dr. Donley. After a few remarks by the new President the remaining officers and committees were elected in a similar manner. The President appointed Collation Committee, C. Merrill Gibson, Craig S. Houston; Publicity Committee, John Walsh, Creighton W. Skelton, Roland Hammond.

The Standing Committee having approved their applications the following were admitted to membership: Herman A. Lawson, Frederick A. Harvey, Julius G. Kelley, Clarence H. Woodmansee, Joseph Franklyn, Kathleen M. Barr, Joseph C. Johnston.

It was voted to make the dues for the ensuing year $5.00. Two hundred dollars was voted to the Medical Library for the purchase of Medical Journals; $250.00 for binding medical journals and $450.00 to the Rhode Island Medical Society for the use of the Medical Library. Dr. Skelton called attention to the advertisement in the Rhode Island Medical Journal of the clinical week of the American College of Physicians. Dr. Jameson reported a case of severe phlebitis following prostatectomy. The patient had chills and fever and massive edema of the leg and appeared to be failing rapidly when following 20 cc. of mercurochrome intravenously the temperature and pulse fell to normal next day but rose again soon when another dose was followed by a severe reaction a falling of temperature and pulse and in a few days a sudden disappearance of the edema. Dr. Sanborn reported a case of apparent tonsillitis followed by a rigid neck and pain and in a few days a loss of power of the left leg. This was apparently anterior poboinyelitis and has resulted in recovery. Dr. Sanborn urged that the society endorse Dr. Hoye's paper especially the part in relation to the need of a psychopathic ward and after much discussion it was voted that the society extend to the city hospital commission a hearty endorsement of the project for a psychopathic ward at the city hospital and that this action be referred to the Publicity Commission. It was also voted that a committee consisting of Drs. Sanborn, Donley, Partridge and the secretary frame this matter so that it may be brought through the Publicity Committee to the public notice.

On motion of Dr. Skelton and after discussion by Drs. McCabe, Armington, Kelley, Hoye and Messinger it was voted that the chair appoint a committee of three to report to the next meeting on the need of a hospial for chronic diseases in this community.

The meeting adjourned at 10:15 p. m. Attendance, 56. Collation was served.

Respectfully submitted,

PETER PINEO CHASE, *Secretary.*

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Edward S. Brackett, Monday evening, February 6, 1928, at 8:45 o'clock. The records of the last meeting were read and approved.

After a few remarks by the President the first paper of the evening was read by Dr. Philip H. Mitchell, Professor of Physiology at Brown University, on "Internal Secretions of the Reproductive Organs." A new method has been evolved of studying the sex cycle of animals by examining vaginal smears. An ovarian hormone was first studied in this way. An extract from follicular liquid or human placenta put into a spayed rat were the most active in bringing on the sex cycle. Corpora lutea in primates were also strong in this hormone. The sex cycle of a monkey is much like that of a woman and all these phenomena can be produced here. The hormone is a growth promoter specific to sexual organs, stimulating the sex cycle, and when its use is stopped menstruation then takes place in the monkey. No commercial preparations have been found to have this hormone. At present it would be very expensive to use. No practical application of this has yet been evolved. The paper was discussed by Drs. Pitts, Perkins, Noyes, McCann and Mitchell.

The second paper of the evening was by Dr. Harry C. Messinger on "Cases of Hypertension Studied with the Aid of the Ophthalmoscope." He cited five cases to show that the retinal arteries showed the nature of arteries in other parts of the body, and detailed the retinal findings in relationship to phases of the disease. The paper was discussed by Drs. Fulton, George Mathews, McDonald, Mowry and Messinger. Dr. George A. Matteson presented a specimen of horse shoe kidney from the first surgical service at the Rhode Island Hospital. Dr. Raymond G. Bugbee presented a case of subtotal resection of the stomach with specimen.

The meeting adjourned at 10:40 P. M. Attendance 70.

Collation was served.

Respectfully submitted

PETER PINEO CHASE, *Secretary*

RHODE ISLAND MEDICO-LEGAL SOCIETY

The Regular Quarterly Meeting was held in the Medical Library Building, 106 Francis Street, Providence, Thursday, January 26, 1928, at 5 P. M.

Program—"Horoscope of the United States, and General Forecast for 1928," by Mrs. Marian Tetreau, of Providence, R. I., Astrological Adviser and Psycho-Analysist.

Following adjournment, a light supper was served.

CREIGHTON W. SKELTON, M.D., *President*
JACOB S. KELLEY, M.D., *Secretary*

WASHINGTON COUNTY MEDICAL SOCIETY

Following is a list of the officers of the Washington County Medical Society for the year 1928:

President—John Paul Jones, M.D.

First Vice-President—John W. Helfrich, M.D.

Second Vice-President—Charles P. Crandall, M.D.

Secretary and Treasurer—John Champlin, Jr., M.D.

Board of Censors—C. Grant Savage, M.D.; J. DeVere Barber, M.D.; John Champlin, M.D.

Delegate to the Rhode Island Medical Society for two years—F. E. Burke, M.D.

Councilor for two years—M. H. Scanlon, M.D.

Alternate Councilor—D. F. Marr, M.D.

Auditor—S. C. Webster, M.D.

P. J. Manning and A. F. MacDonald dropped from the roll of members of the Washington County Medical Society.

JOHN CHAMPLIN, JR., *Secretary*

PERSONALS

Dr. Louisa Paine Tingley of Boston, Mass., and Providence, R. I., has been reappointed Consultant in Ophthalmology on the Staff of the New England Deaconess Hospital, Boston, Mass., for the year 1928.

Dr. Tingley, Consultant in Ophthalmology on the Staff of the Massachusetts Women's Hospital, Boston, Mass., has furnished a room in the new Otis Wing of the hospital in memory of her husband, Frank Foster Tingley.